

Transcript Details

This is a transcript of an educational program. Details about the program and additional media formats for the program are accessible by visiting: <https://reachmd.com/programs/project-oncology/navigating-fertility-preservation-in-young-patients-with-endometrial-cancer/36397/>

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Navigating Fertility Preservation in Young Patients With Endometrial Cancer

ReachMD Announcer:

You're listening to *Project Oncology* on ReachMD. On this episode, we'll hear from Dr. Kathleen Moore, who's a gynecologic oncologist and the Director of the Oklahoma TSET Phase I Program at OU Health Stephenson Cancer Center in Oklahoma City. She'll be discussing how we can manage fertility in younger patients with endometrial cancer. Here's Dr. Moore now.

Dr. Moore:

One of the things that is disturbing is the increase in cancers among an increasingly younger population. And this isn't unique to endometrial cancer. Our breast oncology colleagues have seen this for a long while, but we're seeing patients in their 30s and 40s with desired fertility coming in with diagnoses of endometrial cancer.

The standard of care and often the curative intervention for endometrial cancer is a surgery, which is hysterectomy. And we like to take the ovaries out as well, although that can be preserved in a premenopausal patient to try and preserve ovarian function, but it does remove the ability to bear children yourself. There's all sorts of assisted reproductive technologies available for patients who can afford it. And most of my patients cannot and do not have coverage for ART. So they're really left with this devastating choice to go for a cure and have a hysterectomy or try alternative therapies to try and treat the endometrial cancer in situ and buy them some time, have a pregnancy, and then we recommend a completion hysterectomy after that.

With endometrioid, endocrine-driven, low-grade endometrial cancers that don't show any evidence of myometrial invasion—and we usually judge that based on MRI—we do have established regimens for endocrine interventions. We do use progestins—either medroxyprogesterone acetate or megestrol acetate—used either in cycles or continuously to basically cycle out that thick endometrium which includes the cancer, and then we do “tests of cure,” which is endometrial biopsy every three months until cleared. And then we'll follow for a various amount of time, depending on the age of the patient and her fertility expectations, before we withdraw and let them try to have a pregnancy. And then we follow closely after.

More commonly now, because progestins do cause a lot of weight gain, hair loss, and other side effects, patients tolerate them if it's the only option, but they don't like them. I think the more common intervention now is levonorgestrel IUDs, which give a local endometrial progestin effect, and you get pretty high response rates with this and very few systemic side effects. And depending on a lot of factors, sometimes we use both to try and get a response and then just back down to the IUD alone.

This is such a multidisciplinary discussion with our patients to make sure they really understand the likelihood that they're going to have a live birth and the risks and benefits. But I do think it's important to call out that we do have established regimens for this, and with care, caution, extensive counseling, and multidisciplinary teamwork, we can work together to try our best to help our patients achieve their fertility goals.

ReachMD Announcer:

That was Dr. Kathleen Moore talking about fertility preservation and management strategies in endometrial cancer. To access this and other episodes in our series, visit *Project Oncology* on ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening!